IN THE OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of:

No. 05A-10495-MDX

Ruben J. Marchisano, M.D.,

ADMINISTRATIVE LAW JUDGE DECISION

Holder of License No. 10495 For the Practice of Medicine In the State of Arizona

HEARING: March 31, 2005.

APPEARANCES: The Arizona Medical Board was represented by Assistant Attorney General Stephen A. Wolf. Respondent Ruben J. Marchisano, M.D., did not appear.

ADMINISTRATIVE LAW JUDGE: Brian Brendan Tully

Evidence and testimony were presented and, based upon the entire record, the following Findings of Fact, Conclusions of Law and Recommended Order are made:

FINDINGS OF FACT

- 1. The Arizona Medical Board ("Board") is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona.
- 2. Reuben J. Marchisano, M.D. ("Respondent") is the holder of license number 10495 for the practice of allopathic medicine in the State of Arizona.
- 3. On or about February 5, 2003, the Board initiated investigation MD-03-0150 after receiving a complaint about Respondent's care and treatment of Patient W.E.
- 4. On or about January 4, 2003, Patient W.E. visited Respondent with complaints of abdominal pain, knee pain, coughing, asthma, malaise, chest pain and back pain.

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- 5. Respondent failed to perform an adequate history and physical examination of Patient W.E., which was or might have been harmful or dangerous to the patient.
- 6. Respondent failed to maintain an adequate medical record of this initial office visit with Patient W.E.
- 7. Although the patient complained of abdominal, knee, chest and back pain, Respondent failed to adequately evaluate the nature and source of those pains, which was or may have been harmful or dangerous to W.E.
- 8. Although Respondent was concerned about W.E.'s request for narcotic medication, who he described as "a drug seeker and probably a dealer of hydrocodone/oxycontin", Respondent nevertheless prescribed Tylenol #4 for him, which was or may have been harmful or dangerous to W.E.
- 9. Although his physical examination found W.E.'s lungs to be clear by auscultation, Respondent prescribed small volume nebulizer treatment, which was or may have been harmful or dangerous to the patient.
- 10. The standard of care requires that a physician report to the patient laboratory results in an appropriate and untimely manner.
- 11. Respondent ordered basic chemical panel (CPB), urinalysis and prostate specific antigen (PSA) tests for W.E. Samples were collected on January 7, 2003. The results of the tests were reported to Respondent on January 10, 2003. They showed elevated levels of chloride, triglyceride, GGT and blood in urine. Respondent delayed reporting the positive lab results to W.E. until February 5, 2003, when he was contact by Board staff and instructed to contact W.E. about the results which delay was or may have been harmful or dangerous to W.E. Respondent fell below the standard of care by refusing to report W.E.'s laboratory results in an appropriate and timely manner until the Board intervened.
- 12. Respondent has failed to report a change in residence address, office address and telephone number to the Board. The Complaint and Notice of Hearing and the Amended Complaint and Notice of Hearing were mailed to Respondent at his residence address and office address of record with the Board.

CONCLUSIONS OF LAW

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- 1. The Board has jurisdiction over Respondent and the subject matter in this case.
- 2. The conduct and circumstances described in the above Findings of Fact constitute unprofessional conduct by Respondent pursuant to A.R.S. §32-1401(27)(q) (any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public).
- 3. "Adequate medical records" means legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2).
- 4. The conduct and circumstances described in the above Findings of Fact constitute unprofessional conduct by Respondent pursuant to A.R.S. § 32-1401(27)(e) (failing or refusing to maintain adequate records on a patient).
- 5. Each active licensee is required to promptly and in writing inform the Board of the licensee's current residence address, office address and telephone number and of each change in residence address, office address or telephone number that may later occur. A.R.S. § 32-1435(A). The Board may assess the costs incurred by the Board in locating a licensee and in addition a penalty of not to exceed \$100.00 against a licensee who fails to promptly inform the Board within thirty days from the date of change. A.R.S. § 32-1435(B).
- 6. The conduct and circumstances described in the above Findings of Fact constitute unprofessional conduct by Respondent pursuant to A.R.S. § 32-1401(27)(s) (violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any provision of the medical practice act).

RECOMMENDED ORDER

In view of the foregoing, it is recommended that the following actions be taken against Respondent's License 10495 on the effective date of the entered Order in this matter:

- The issuance of a Letter of Reprimand.
- Probation for a period of one year. During the probationary period Respondent shall complete 10 hours of continuing medical education in record keeping, which shall be in addition to any required continuing medical education requirements. The probation shall be tolled until such time as Respondent notifies the Board that he is practicing in Arizona.
- A penalty in the amount of \$100.00, pursuant to A.R.S. § 32-1435(B), which shall be paid on or before the expiration of the probation.

Done this day, March 31, 2005.

Brian Brendan Tully
Administrative Law Judge

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